No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY BRIEF FOR PETITIONERS VACCO AND PATAKI

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I. PLAINTIFFS MISCHARACTERIZE NEW YORK LAW WITH RESPECT TO ITS TREATMENT OF PATIENTS WHO EXERCISE THE RIGHT TO REFUSE OR WITHDRAW FROM MEDICAL TREATMENT

As a matter of law in New York, a mentally competent adult patient, whether or not terminally ill, has a right to be free of bodily intrusion and, as a corollary, can refuse or withdraw informed consent to medical treatment, including that

which is life-sustaining. *See, e.g., Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990) (patient not terminally ill); *Matter of Storar*, 420 N.E.2d 64 (N.Y. 1981) (patient terminally ill). A physician may not proceed with treatment in such a circumstance. *Rivers v. Katz*, 495 N.E.2d 337, 342-43 (N.Y. 1986). Regardless of the presence of terminal illness, New York law honors the voluntary request of a competent patient to withdraw from or refuse medical treatment.

Plaintiffs are simply wrong in suggesting (Br. pp. 10-11) that New York inquires into the motivation of individuals who are not terminally ill and seek to exercise this right. Plaintiffs mischaracterize *Fosmire v. Nicoleau*, which held that a competent adult who had no terminal illness had the right to refuse life-sustaining blood transfusions. Although the Court of Appeals observed, as plaintiffs note, that the patient did not "want to die," 551 N.E.2d at 82 n. 2, this lack of intent to die was not the basis for its holding that the patient should have been permitted to refuse treatment. Rather, said the Court, although "[t]he State will intervene to prevent suicide," "merely declining medical care, even essential treatment, is not considered a suicidal act." *Id.* at 82.

This is hardly the same thing as "remaining neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 280 (1990). Thus, in *Von Holden v. Chapman*, 450 N.Y.S.2d 623 (4th Dept. 1982), the State was allowed to insert a nasogastric feeding tube in a prisoner in custody in a state psychiatric center who had refused to eat for 22 days but was receiving no medical treatment. Plaintiffs' characterization of the case to the contrary (Br. p. 11) is incorrect. *See id.* at 627 ("essential dissimilarity" of "right to decline medical treatment" and "right to take one's life").

There is thus no basis for plaintiffs' unsupported assertion (Br. pp. 11, 47) that "assisting one whose specific intent [is] to kill himself by the disconnection or termination of some life-sustaining treatment . . . could violate New York's law against aiding in suicide." Regardless of either the presence of terminal illness or the underlying intent, New York honors the voluntary decision of a competent patient to withdraw from or refuse medical treatment. *See infra* n. 3.

II. THE SUBSTANTIVE COMPONENT OF THE FOURTEENTH AMENDMENT DUE PROCESS CLAUSE DOES NOT ENCOMPASS A FUNDAMENTAL RIGHT TO OBTAIN THE ASSISTANCE OF A PHYSICIAN IN COMMITTING SUICIDE

Despite the highly charged and inconsistent terms used (Pl. Br. pp. 1, 3, 19, 24), the constitutional "right" plaintiffs are seeking is the right of mentally competent, terminally ill adults to obtain a physician's assistance in committing suicide (J.A. 28).[1] *See Reno v. Flores*, 507 U.S. 292, 302 (1993) (" 'substantive due process' analysis must begin with a careful description of the asserted right"). Any such asserted right is entitled to heightened constitutional protection under the substantive component of the Fourteenth Amendment's Due Process Clause only if it is " ' "so rooted in the traditions and conscience of our people as to be ranked as fundamental." ' " *Id.* (citations omitted). Whether viewed purely from the standpoint of historical practice or considered in terms of the substantive due process rights that have heretofore been protected by this Court, the asserted right to a physician's assistance in committing suicide cannot be deemed fundamental.

The simplest due process approach to this case is the one correctly taken by the court below. The Second Circuit, rec-

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[1] References to the Joint Appendix are cited as (J.A.). *Amicus curiae* briefs are cited as "Br. of ___." *Amicus curiae* briefs in *Washington v. Glucksberg*, No. 96-110, are cited as "Br. of ___ (Glucksberg)."

ognizing that fundamental liberties are only "those that are 'deeply rooted in this Nation's history and tradition,' " noted that "the very opposite is true" of the right asserted by plaintiffs (J.A. 231-232) (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)). Citing scholarship demonstrating that the English common law, the American colonies, and most states at the time of the enactment of the Fourteenth Amendment prohibited suicide and attempted suicide (J.A. 232-33), *see also* T. Marzen, et al., *"Suicide: A Constitutional Right?"—Reflections Eleven Years Later*, 35 Duq. L. Rev. 261, 262-268 (1996); Br. of Members of New York and Washington State Legislatures, pp. 8-23, the court then observed that most states today make assistance in suicide a crime, while no state has ever recognized a "right" to assisted suicide (J.A. 233).[2] Acknowledging the need to exercise restraint " 'because the guideposts for responsible decision-making in this uncharted area are scarce and open-ended,' " the Second Circuit properly declined "to identify a new fundamental right" (J.A. 233-34) (quoting *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992)). *See also Michael H. v. Gerald D.*, 491 U.S. 110, 122 n.2 (1989) ("[t]he protection need not take the form of an explicit constitutional provision or statutory guarantee but it must at least exclude . . . a societal tradition of enacting laws *denying* the interest").

Plaintiffs acknowledge "that most states historically have forbidden physicians to provide life-ending medication to their suffering patients" (Br. p. 27) but ask this Court to locate substantive due process rights in "historically enduring principles" as well as "concrete historical practices" (Br.

[2] In the past five years, the legislatures of fifteen states have debated the issue and decided to retain their prohibitions, and nine other states have strengthened their statutory prohibitions. Br. of Sen. Orrin Hatch et al., p. 25. Clearly, "the balance struck by this country," whether regarded in terms of "the traditions from which it developed" or "the traditions from which it broke," *see Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting), is overwhelmingly to prohibit physicians from prescribing medications for the purpose of causing death.

p. 22). Even if this Court accepts the invitation, the conclusion remains the same. The principles underlying this Court's prior recognition of substantive due process rights do not embrace a right to a physician's assistance in suicide.

Plaintiffs' argument rests primarily and unsuccessfully on this Court's decisions in *Cruzan* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Plaintiffs first contend (Br. pp. 19-21) that the asserted right of a "competent, terminally ill patient" to choose assisted suicide is congruent to the right recognized in *Cruzan*, which, according to plaintiffs, extends only to a seriously ill or dying person. There is no such limitation in *Cruzan*. The Court in that case mentioned that Nancy Cruzan had "virtually no chance of recovering her cognitive faculties," 497 U.S. at 265, purely as a descriptive matter. The right to withdraw from or refuse treatment extends to all. *See Schloendorff v. Society of New York Hospital*, 105 N.E.2d 92, 93 (N.Y. 1914) (Cardozo, J.). And as the *Cruzan* Court also made clear, the exercise of the right is readily distinguishable from any suicidal act, which may be prevented by the state. 497 U.S. at 280.

Plaintiffs' strained reading of *Cruzan* and the right it recognizes is evidenced also in their argument (Br. p. 25) that the recognition of "bodily integrity," 497 U.S. at 269, encompasses both a right to avoid bodily intrusion and a right to obtain "desired medical intervention."[3] But—as the cases cited by plaintiffs indicate and the word itself suggests[4]—"integrity" is a defensive right only. *See Washington v. Harper*, 494 U.S. 210 (1990) (right to avoid unwanted administration of antipsychotic drugs); *Rochin v. California*, 342

[3] Underlying plaintiffs' argument is the entirely unsupported proposition that the prescribing of drugs to kill a patient is a medical treatment. *See* Br. of American Medical Association, et al., pp. 4-5.

[4] The word derives from the Latin *integer*, meaning intact or untouched.

U.S. 165 (1952) (right to avoid forcible stomach pumping); *Schloendorff*, 105 N.E.2d 92 (common law right to damages for unconsented-to medical treatment). Indeed, this Court in *Casey* identifies *Cruzan*, *Harper*, *Rochin* and other cases only as "recognizing limits on governmental power to mandate medical treatment or to bar its rejection." *See* 505 U.S. at 857. This does not encompass or suggest a limitation on governmental power to prohibit death-causing intervention.

Nor is it true, as plaintiffs claim (Br. p. 29), that *Cruzan*'s recognition of a right to refuse treatment "can only be understood as a recognition of the liberty . . . to physician assistance in ending one's life." The individual interest at issue in *Cruzan* is not in death but in terminating treatment. *See* 497 U.S. at 279 ("a constitutionally protected right to refuse life-saving hydration and nutrition"); *id.* at 287 (O'Connor, J., concurring) ("a protected liberty interest in refusing unwanted medical treatment"); *id.* at 302 (Brennan, J., dissenting) ("a fundamental right to be free of unwanted life support"). While the Court in *Cruzan* notes that "[t]he choice between life and death is a deeply personal decision," the holding of the case is simply that the State "may legitimately seek to safeguard the personal element of this choice" with a heightened evidentiary standard. 497 U.S. at 281.

Plaintiffs' argument is not bolstered by reference to the recognition in *Casey* that the substantive due process right identified in *Roe v. Wade*, 410 U.S. 113 (1973), embraces both a right to choose and a right to avoid abortion. *See Casey*, 505 U.S. at 859. This shows, plaintiffs say (Br. p. 30), "that the liberty to make protected decisions is a two-way street." But this changes nothing about *Cruzan*, because the right to refuse treatment can by definition be exercised only defensively. In prohibiting assisted suicide, New York is not placing improper limits on which "way" the negative right in *Cruzan* will be exercised; there is only one way it *can* be exercised.[5]

[5] This is why plaintiffs' concerns about "a State deciding to prohibit extraordinary treatment for suffering patients who are about to die" (Br. p. 30) are inapposite. The fact that a negative right to refuse treatment can be exercised only in one "way" has no bearing on the viability of any positive right to receive or demand medical treatment.

See G. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 Seattle U. L. Rev. 473, 479 (1995) (acknowledgement of "negative right" to refuse treatment does not create a duty to respect "positive right" to physician assisted suicide). Rather, the State is applying a prophylactic rule to a dangerous and hitherto-unrecognized positive "right."

Nor is plaintiffs' argument more persuasive when it moves further from *Cruzan* in the direction of *Casey*. *Casey*'s relevance to the present case is extremely problematic. The reaffirmance in *Casey* of a woman's constitutionally-protected liberty interest in choosing an abortion was based largely on "the rule of *stare decisis*." 505 U.S. at 845-46; *see also id.* at 866-67 (relying on "precedential force" of *Roe v. Wade*). Moreover, *Casey* rested in part on the importance of the right it recognized to the achievement of gender equality. *See id.* at 852 (state cannot "insist, without more, upon its own vision of the woman's role"); *id.* at 856 ("the ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives"). *See also* R. Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1200 (1992) (emphasizing "the women's equality dimension of the issue" in *Roe* and *Casey*). No comparable interest applies to physician assisted suicide.

Casey cannot be relied on in the present case, as plaintiffs attempt (Br. pp. 23-25), for its recognition that substantive due process protects "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy" that "define the attributes of personhood," 505 U.S. at 851, or its understanding of the "intimate and personal" nature of a woman's "suffering." 505 U.S. at 851-852. This language, taken (as plaintiffs take it) literally

and out of the "unique" context of abortion, 505 U.S. at 852, would encompass a vast range of intimate personal decisions.

Plaintiffs implicitly recognize the potential for chaos in applying *Casey*'s language so literally. Thus, in an effort to assuage fears of widespread abuse, they define eligibility for the asserted right narrowly: one must be among the suffering terminally ill. In invoking *Casey*'s language, however, plaintiffs speak only in general terms of pain and personal autonomy, and liken the right they assert to other rights whose exercise is not limited to a specific segment of society. If, as plaintiffs suggest, the autonomy-based right to assistance in suicide can properly be exercised only by the terminally ill and "closely regulated" by the State, it is difficult to see how it can possibly be "fundamental."

Moreover, plaintiffs (Br. pp. 19-20) are suggesting that the terminally ill alone may obtain assistance in suicide because their quality of life is so diminished that "[t]he choice of how to die is the only choice left to [them]." This consolatory approach, requiring the creation of new rights when others cannot be exercised, is not how the acknowledgement of fundamental rights works. Nor is it apparent why this analysis limits the application of the right, for it can readily be said of anyone whose quality of life is, in his own or someone else's view, diminished in any significant way. And in any event, a judgment as to the "quality of life" is something that, according to this Court, a state need not make. *Cruzan*, 497 U.S. at 282. If a state may decline to make such a judgment, surely the Constitution does not require it to do so or to give effect to such a judgment.

Plaintiffs' argument that there is a fundamental right to assistance in suicide is undermined by an additional contradiction. On the one hand, they recognize the gravity and profundity of death and the irreducibly personal nature of dying. On the other hand, they suggest (Br. pp. 30-31) that "advances in medical technology" and "[t]he development of

increasingly sophisticated life-prolonging treatment" impart a new urgency to the right they assert. But the fact of death is a constant in nature and in human and American history. Neither its profundity nor its mystery nor its centrality has ever been deemed to justify a right to obtain assistance in committing suicide, even though the right to refuse treatment has always been recognized.[6] And though it may be that we die differently today than we did a hundred (or twenty) years ago, we do not necessarily die worse. Did death in an earlier age entail an end *less* "filled with life-encompassing pain, disintegration or suffering"? Given modern advances in pain relief and palliative care, it seems impossible, even when these advances are not fully deployed. *See generally* New York State Task Force on Life and the Law ("Task Force"), *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* ("*When Death Is Sought*") 35-47 (1994). Neither the misery nor the mystery of death is a new phenomenon. The law has always treated them with appropriate solemnity, yet they have never been deemed to give rise to a right, "fundamental" or otherwise, to obtain assistance in suicide.

The right to assistance in suicide that plaintiffs claim can be found nowhere in the text of the Constitution. Its exercise has always been, and continues to be, prohibited by the great majority of the states. Nor can it be derived from either the language or the holding of *Cruzan* or *Casey*. It is, in plaintiffs' own formulation, activated by precisely the supposedly diminished quality of life of the terminally ill that is not constitutionally cognizable. And it is compelled neither by the profundity and mystery of death nor by the particular circumstances of dying in contemporary America. However the

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[6] Plaintiffs suggest (Br. p. 32), absolutely without support, that "Due Process would not, in the 18th through mid-19th centuries, likely have been thought to include the right to avoid the artificial prolongation of life." On the contrary, as *Cruzan* recognized, the right derives unchanged from the English common law.

right to assistance in suicide is viewed, it is not "fundamental" and thus is not entitled to heightened protection under the Due Process Clause.

III. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE IS A PERMISSIBLE MEANS OF VALIDATING ITS LEGITIMATE INTERESTS

The proper approach to a substantive due process case is clearly articulated in *Reno v. Flores*.[7] Any state infringement of a fundamental right must be "narrowly tailored to serve a compelling state interest," while "[t]he impairment of a lesser interest . . . demands no more than a 'reasonable fit' between governmental purpose . . . and the means chosen to advance that purpose." *Reno v. Flores*, 507 U.S. at 302, 305. As demonstrated in the preceding section, the right asserted by plaintiffs is not "fundamental" in nature. Thus, as long as there is a "reasonable fit" between New York's purposes in prohibiting assisted suicide and the prohibition itself, the law is not unconstitutional.

The interests asserted by New York demonstrate the reasonableness of its prohibition of assisted suicide. As discussed at length in the equal protection context in defendants' main brief (pp. 20-26), the State asserts the interest in "the protection and preservation of human life" that, according to *Cruzan*, justifies state "laws imposing criminal penalties on

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[7] The standard by which to judge the validity of New York's prohibition does not, as plaintiffs argue (Br. p. 34), derive from *Casey*. The plurality opinion in that case affirmed the conclusion of *Roe v. Wade* that women have a substantive due process right to abortion that can be limited only by state regulation that does not impose an "undue burden" on or a "substantial obstacle in the path of" the exercise of that right. *Casey*, 505 U.S. at 877. *Casey*'s approach presupposes a substantive right that is deemed "fundamental" under the Due Process Clause, a right not found here. And if, as the United States Solicitor General proposes, the "undue burden" standard is something less than strict scrutiny, then New York's prohibition survives that review because, as plaintiffs have conceded (Br. p. 37), the State's interests are compelling.

one who assists another to commit suicide." 497 U.S. at 280. Plaintiffs now argue (Br. p. 35) that the State's interest is "fatally undermined" by its authorization of "the life-ending withdrawal of treatment." As *Cruzan* makes clear, however, the criminalization of assisted suicide can coexist with the right to terminate treatment, which derives from the common law of informed consent, may be exercised by the terminally ill or anyone else, and cannot be absolutely prohibited by a state. *See Cruzan*, 497 U.S. at 270, 279, 281-82.

This analysis does not change when the use of drugs with a "double effect" is considered. As medical literature cited by plaintiffs demonstrates, physicians recognize "the primacy of comfort as the dominant goal of care." N. Cherney & R. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. Palliative Care 31, 35 (1994). Sometimes, achievement of this goal requires that a physician administer a pain-relieving drug in doses large enough to have the possible side effect of fatal depression of respiration. This potential "double effect" is accepted throughout medicine, and is acknowledged, for example, whenever physicians perform surgery that entails (or involves the use of an anaesthetic that entails) a foreseeable risk of unintended death. Because the physician's purpose is to cure or palliate rather than kill, administration of the drug is not assisted suicide.

Similarly, patients near death occasionally suffer such "refractory" pain that the primary goal of "adequate relief of intolerable symptoms" requires "impair[ment] of the [patient's] conscious state." *Id.* at 34. The physician administers a sedative—an opioid, a benzodiazepine, or (rarely) a barbiturate—which provides relief but increases the risk of accelerating death. *Id.* at 35. Again, this is no different from any other medical procedure that balances the frequently incompatible goals of "prolonging survival," "optimizing comfort" and "optimizing function." *Id.* at 34. Sometimes, too, a physician will administer a sedative prior to fulfilling

a patient's informed and competent request to terminate life-prolonging treatment, *see* R. Truog, et al., *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678, 1680 (1992), thus properly minimizing the patient's suffering. But plaintiffs' repeated suggestion (Br. pp. 15-16, 49-50) that a patient may "consen[t] to be made unconscious, rendering him dependent on life support . . . and then deliberately caus[e] his own death by having a physician withhold" life-sustaining treatment is utterly without support in the record and unquestionably outside the bounds of accepted medical practice.

Indeed, the very article on which plaintiffs rely for the concept of "terminal sedation" rejects any notion that it is a practice used to cause or induce death:

> Although proponents of physician-assisted suicide and euthanasia contend that terminal sedation is covert physician-assisted suicide or euthanasia, the concept of sedating pharmacotherapy is based on informed consent and the principle of double effect.

P. Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Arch. Intern. Med. 1785, 1785-86 (1996). The predicate for terminal sedation is "refractory" physical and psychosocial symptoms, that is, symptoms that are unresponsive to treatment. *Id.* "Although relief of symptoms with a preserved function is the usual goal of medicine . . . relief of suffering may predominate over all other considerations, including maintenance of consciousness." *Id.* But the practice contemplates only the level of medication required to control symptoms, and thus not all will be rendered unconscious. *Id.* Finally, the practice envisions only a "current do-not-resuscitate order" so that when death arrives, unwanted life-prolonging measures are not used. *Id.*

At least as important as the State's interest in protecting human life is its interest in avoiding error and abuse. As plaintiffs themselves note (Br. p. 37), "the protection of

people who might seek to end life mistakenly or under pressure is a compelling interest." The dimensions of this interest are discussed at length in defendants' main brief (pp. 27-32) and many *amicus* briefs, and will only be summarized here: the risk of error inherent in any determination of "terminal" illness, given the absence of any clear-cut definition of the term and the facts that doctors typically make poor judgments about the period of life remaining to the terminally ill and that their prognoses of survival time fail to account for variations in treatment, *see* Br. of American Geriatrics Society, pp. 16-21, National Hospice Organization, pp. 14-15; the impossibility of reliably measuring pain or suffering if they are to be aspects of a valid exercise of the right to assistance in suicide, *see* Br. of American Geriatrics Society, p. 25; the problematic nature of the voluntariness of a request for suicide and the competence of one who makes such a request in light of the possibility of inadequately-treated pain or undiagnosed and undertreated depression, *see* Br. of Project on Death in America, et al., pp. 15, 23, American Medical Association, et al., p. 13, American Geriatrics Society, p. 21; the erosion of voluntariness attributable to overwhelming financial pressures, whether exerted by families or by managed care organizations, with their strong economic incentives to limit medical treatment, *see* Br. of International Anti-Euthanasia Task Force, *passim*, American Medical Association, et al., p. 13, Project on Death in America, p. 20; the same concern about voluntariness due to the imbalance and dependency inherent in the physician-patient relationship, *see* Task Force, *When Death Is Sought* at 73, 121; the fact that the risk of error and abuse is enhanced for the poor and minorities, who are especially likely to receive inadequate diagnosis and treatment and especially vulnerable to financial pressures, *see* Br. of American Medical Association, et al., p. 13; and the fact that any regulation of decisions about assisted suicide would require an unprecedented intrusion into the physician-patient relationship, *see* Br. of American Medical Association, et al., p. 17.

Plaintiffs acknowledge the legitimacy of these concerns, but suggest (Br. pp. 37-38) that they do not "require a complete ban on the provision of life-ending medication" to those with "the right to self-administer such a prescription drug." The sole possessor of such a right, according to plaintiffs (Br. p. 21), is the "competent, terminally ill patient [who may] choose whether to endure a death marked by intolerable agony, degradation, and suffering." Plaintiffs reject the possibility that the freedom they claim will perforce be extended to others who (they agree) do not have a constitutional right to exercise it. On the other hand, they insist (Br. p. 38) that the fact that New York limits but does not ban the withdrawal from life-prolonging treatment means that "less restrictive measures" than an outright prohibition must be employed to regulate assisted suicide as well.

Plaintiffs' argument collapses under the weight of this contradiction. As noted in defendants' main brief (pp. 21-24), if the justification for invalidating New York's ban is the equivalence between assisted suicide and termination of treatment, then the right claimed by plaintiffs simply cannot be limited as they say it must be in order to survive constitutional scrutiny. If, however, the right can be exercised only upon the error-prone determination of far more factors than are entailed in deciding whether to give effect to a request to withdraw from life-prolonging treatment, then the greater risk of error connected with physician assisted suicide justifies New York's prohibition of it.

Even if plaintiffs were somehow correct in suggesting that the "right" to assistance in suicide can be limited to the terminally ill, they remain wrong in the central assertion of their argument (Br. pp. 38-39): that "[t]he precise risks about which the State claims to be concerned [with respect to assisted suicide] are of course equally present" in decisions to withdraw from life-prolonging treatment. For several reasons, the risks are greater with physician assisted suicide.

First, patients wishing to terminate life support are, by definition, already receiving substantial medical care, whereas those who choose assisted suicide may be doing so in lieu of unavailable or inadequate medical attention. Br. of American Geriatrics Society, p. 12. The risk of error and involuntariness due to, for example, inadequate pain control or undiagnosed and untreated depression is thus far greater with assisted suicide, even among the terminally ill.

Moreover, severely ill persons who wish to kill themselves share with other suicidal individuals a clinical profile characterized by depression and extreme anxiety, whereas such a profile is not typical of seriously ill patients who elect to terminate life-supporting medical interventions. *See* Br. of American Suicide Foundation (*Glucksberg*), pp. 5-15. In other words, when comparing risks, a terminally ill patient's choice of suicide is substantially less likely to be truly voluntary than a terminally ill patient's choice to terminate treatment.

Furthermore, as demonstrated by the amicus brief of the American Geriatrics Society (pp. 16-21), predictions of death from the natural course of serious illness can be formulated only as probability judgments encompassing a wide range of time spans for virtually all serious illnesses.[8] This inherent uncertainty of prognostic data severely undermines plaintiffs' case, which distinguishes those in "the final stages of a terminal illness" by virtue of the supposed certainty of their imminent deaths. An individual who discontinues treatment because he mistakenly thinks death is imminent may well, as plaintiffs put it, survive and "live to rejoice" (Br. p. 20). But many individuals who request assistance in suicide on the basis of the same, inherently unreliable information will have

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[8] For example, "the actual survival curve for persons with less than a 50% chance to live six months" according to one prognostic model reveals that most "terminal" illnesses have "a substantial 'tail' of long term survivors: more than one-fifth of some patient groups are alive after two years." J. Lynn, et al., *Defining the 'Terminally Ill:' Insights from SUPPORT*, 35 Duq. L. Rev. 311, 320 (1996).

their lives cut needlessly short. These differences in the risk attendant upon the uncertainty of a prognosis of terminal illness justify New York's prohibition of assisted suicide while it permits termination of treatment.

The prevalence of managed care increases the risk of error by and abuse of patients who choose suicide relative to those who withdraw from treatment. The brief *amicus curiae* of the International Anti-Euthanasia Task Force (p. 30) notes the cost-effectiveness of "managed death." To put it bluntly, it is cheaper to kill patients at once than to treat them at length. As one article notes, patients may raise the possibility of assisted suicide early in the disease process, perhaps upon "the initial announcement . . . of a frightening diagnosis," whereas discussions and decisions substantially in advance of death about terminating life-prolonging treatment are uncommon, despite efforts to promote earlier decision-making. S. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 Duq. L. Rev. 455, 474 (1996). Moreover, research that projects savings from such termination "has concluded those savings are modest at best," perhaps because those who terminate life-prolonging treatment then require costly palliative care instead. *Id.* at 475. Thus, there are significant financial incentives in the one situation that are often not present in the other.

Nor are the risks which would accompany legalization of assisted suicide speculative, for as noted in defendants' main brief (p. 24 n. 13), the actual experience of the Netherlands with euthanasia and assisted suicide is instructive. First, it is abundantly clear that Dutch guidelines designed to assure, *inter alia*, the voluntariness of the choice of death are frequently neglected. *See, e.g.*, L. Kass & N. Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 Duq. L. Rev. 395, 412-13 (1996). Furthermore, the very article upon which plaintiffs rely to dismiss defendants' concerns about adoption of the Dutch approach reveals that in 1995, 0.7 percent of deaths in the

Netherlands involved ending a patient's life without his or her explicit request. P. van der Maas, et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 New Eng. J. Med. 1699, 1700 (1996). The equivalent in the United States, where there are 2.3 million deaths annually, is more than forty deaths a day attributable to nonvoluntary euthanasia.[9] The risk is very real.

Thus, no matter what the scope of the asserted "right," whether extended only to the terminally ill or otherwise, New York may ban its exercise entirely. *Cruzan* observes that even as a state must recognize the right to refuse medical treatment, it may assert its interest in the protection of human life by prohibiting assistance in suicide. Moreover, there are many reasons to believe that the risk of error and abuse is significantly greater with assisted suicide than with withdrawal from treatment, especially under the regime of managed care that increasingly dominates the provision of health care services in America. These state interests are concededly not only rational but compelling. The difference in nature and risk between assisted suicide and withdrawal from life-prolonging treatment means that prohibiting the former while allowing the latter "is not excessive in relation to th[ose] valid purpose[s]." *Reno v. Flores*, 507 U.S. at 303. Accordingly, New York's ban on assisted suicide does not violate the substantive component of the Due Process Clause.

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[9] Plaintiffs, suggesting (Br. p. 41 n. 21) that there may be more such nonvoluntary euthanasia in the United States than in the Netherlands, cite a study suggesting that 7% of critical care nurses in the United States have engaged in nonvoluntary euthanasia, while ignoring the fact that 23% of Dutch physicians have done so. *See id.* at 1701. Moreover, the study they cite has been widely and severely criticized for its methodological flaws. *See, e.g.*, C. Scanlon, *Euthanasia in Nursing Practice—Right Question, Wrong Answer*, 334 New Eng. J. Med. 1401 (1996).

IV. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE DOES NOT VIOLATE THE EQUAL PROTECTION CLAUSE

The foregoing discussion leaves little to add to the exploration of the equal protection issue in defendants' main brief. The assumed existence of a substantive due process right to withdraw from life-prolonging treatment does not suggest an equivalent right to assistance in suicide. *See San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 33 (1973) ("it is not the province of this Court to create substantive constitutional rights in the name of guaranteeing equal protection of the laws"). New York law, of course, makes no "classification" of the sort essential for equal protection analysis. All New Yorkers may exercise the right to terminate unwanted medical treatment; none may exercise the "right" to assist or be assisted in suicide. New York's policy thus cannot violate the Equal Protection Clause. *See, e.g., Personnel Administrator of Massachusetts v. Feeney*, 442 U.S. 256, 271-274 (1979) (disproportionate negative impact of facially neutral and otherwise valid state law does not violate equal protection unless it affects a historically-disadvantaged group and was enacted for a discriminatory purpose); Pl. Br. p. 10 (acknowledging that terminating treatment is not viewed under New York law as a suicidal act).

But even if New York's approach is deemed a "classification," it survives constitutional scrutiny. As plaintiffs concede (Br. pp. 44-45), the Equal Protection Clause requires in the present case only that a statutory classification be rationally related to a legitimate state purpose. Like the court below, plaintiffs rely (Br. p. 45) on the supposed similarities between "providing life-ending medication" and "withdrawing life-sustaining treatment." For the reasons discussed in defendants' main brief and in the preceding section of this brief, however, assisted suicide and withdrawal from life-prolonging treatment differ both inherently and with respect to the risks they present. It was reasonable for the New York Legislature to consider these differences and prohibit one practice while permitting the other.[10] *See* Pl. Br. p. 37 (State's interests in preventing abuse and mistake are "compelling").

We note in conclusion that the balance struck by the New York Legislature between the exercise of individual autonomy by those who truly want to commit suicide and the protection of the many vulnerable citizens who do not is desirable but not inevitable. The fact remains, however, that never once in American history has a patient lawfully obtained a physician's assistance in committing suicide. A declaration that there is a right to do so would be a leap—from near universal prohibition to constitutional obligation—unprecedented in this Court's history. There is no basis for such a leap.

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[10] Plaintiffs' argument (Br. p. 48 n. 25), following the concurrence of Judge Calabresi in the court below, that there is no evidence of recent legislative consideration of the issues in this case, is belied by, *inter alia*, (1) the 1990 enactment of the New York Health Care Proxy Act, which permits a "health care agent" to make decisions about withdrawal of artificial nutrition and hydration, but "is not intended to permit or promote suicide, assisted suicide, or euthanasia," N.Y. Pub. Health L. § 2989(3) (McKinney 1993 & Supp. 1996); and (2) the presentation in 1994 to the Legislature of the report of the Task Force, *When Death Is Sought*, which unanimously recommended that the law not be changed to permit assisted suicide, *see When Death Is Sought* at xii.

CONCLUSION

THE JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT SHOULD BE REVERSED WITH RESPECT TO ITS EQUAL PROTECTION HOLDING AND OTHERWISE UPHELD.

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Respectfully submitted,

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